Public Process for Determining Rates for Long-Term Care Facilities

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

KENTUCKY CASE MIX ASSESSMENT AND REIMBURSEMENT (CMAR) SYSTEM

RESIDENT ASSESSMENT

INTRODUCTION

The Kentucky Department for Medicaid Services is implementing a new reimbursement system for long term care facilities participating in the Medicaid program. Provisions of the Omnibus Budget Reconciliation Act of 1987, Title XIX of the Social Security Act, eliminate the current level of care distinctions between intermediate care (ICF) and skilled nursing facilities (SNF) effective October 1, 1990. As a result of this action the Kentucky Medicaid program will alter its present reimbursement system to provide for reimbursement that is reasonable and adequate in order to assure access to quality care for Kentucky's long-term care population.

Therefore, Kentucky is implementing a new reimbursement system which is dependent on the specific care needs of each patient residing in long term care facilities. This form of reimbursement will be known as the Case Mix Assessment and Reimbursement (CMAR) System. The objective of the CMAR is to improve reimbursement for facilities providing services for patients with higher care needs in order to improve access to care for these recipients and to provide for the care needs for elderly population with lesser care needs and who may be able to stay in the community with only minimal assistance.

There will be four major categories of costs:

- Nursing Services
- Other Care-Related Costs
- Other Operating Costs
- Capital Costs

The cost associated with the direct provision of care (i.e. nursing costs) will be facility specific and will be weighted according to the respective mix of residents within a given facility. This form of assessment system is a "facility-specific" system and the nursing facility (NF) is reimbursed based on the average of the mix of the care needs of their residents at a particular point in time.

This entails a redetermination of the facilities' mix of residents each quarter in order to establish a new facility specific nursing rate each quarter. There will be quarterly assessments of the care needs of each resident of the facility with an established case mix assessment system.

A. Nursing Costs:

Facility nursing costs are defined as all direct costs associated with the direct provision of care. Nursing services cost will be separated into urban and rural arrays based on Standard Metropolitan Area definitions. Nursing services cost will be subject to an upper limit set at 115% of the median of the array of the nursing cost per case mix unit. The cost per case mix unit is derived by dividing the nursing cost per day by the average value of the nursing assessments for the facility. Designated supply items previously covered under ancillary services, such as diapers, syringes, and catheters, will be covered under the nursing routine cost center.

B. All Other:

All other costs are all costs including capital costs which are not considered as direct nursing costs. These costs reflected on a per diem basis likewise will be separated into urban and rural arrays based on Standard Metropolitan Area definitions. All Other cost will be subject to an upper limit set at 115% of the median of the array of the All Other cost per diems.

Hold Harmless. The NFs will (except as otherwise specified herein) be entitled to a "hold harmless" amount for the period from October 1, 1990 through June 30, 1992. The hold harmless amount is the amount, if any, by which the July 1, 1990, allowable (subject to audit adjustment) facility rate plus an adjustment for ancillary costs being shifted to routine costs (less a nurse aide training per diem allowance of $1.20) exceeds the allowable facility rate as computed on October 1, 1990, (subject to audit adjustment) and July 1, 1991, (excluding the revised nurse aide training per diem allowance and other per diem add-ons in recognition of OBRA 87 requirements) under the revised reimbursement system ("case mix"). For hold harmless purposes, the July 1, 1990, rate will be increased by an inflation allowance using the appropriate Data Resources, Incorporated index for inflation. The hold harmless provision shall not be applicable for nursing facility services provided in hospital swing beds or dual licensed hospital beds.

Cost Savings Incentive. Providers (except NF/MRSs) will be eligible for a Cost Savings Incentive (CSI) factor if the facility rate is not in excess of 110 percent of the median of the array. CSI payments will be computed on both the Nursing and All Other cost centers. It will be ten (10) percent of the difference between the facility's per diem cost and the upper limit from the appropriate array. The CSI will be limited to no more than $1.50 per diem for each of the two cost categories. NF/MRSs shall have a cost savings incentive amount computed as 10 percent of the difference between the facility's case mix rate and the upper limit for the class of facility (with the CSI not to exceed $1.50 per diem per facility for each of the two cost categories).

Case Mix Rate Adjustments. Rates will be recomputed quarterly based on revisions in the case mix assessment classification which affects the Nursing Services component. However, the cost basis and the upper limits will be revised annually using the latest available cost reports and assessments from each provider.

Infectious Diseases. An add-on amount of $1.38 for universal precautions will continue as previously specified through June 30, 1991, and has been determined to meet the cost of both universal precautions (pursuant to OSHA) and infection control (pursuant to OBRA 87). The special rates for individuals with highly infectious or communicable diseases which have limited treatment potential will be discontinued; however, a special access and treatment fee of $10 will be added to the facility per diem for each individual identified as falling within that group.

Hospital Based NFs. Hospital based NFs shall be excluded from the facility cost arrays, and these NFs shall have an upper limit set at 125 percent of the upper limit for freestanding facilities with the comparison made against the appropriate urban or rural array.

Dual Licensed Pediatric Facilities and NF/Institutions for Mental Diseases. These NFs shall be excluded from the facility cost arrays and paid at full reasonable and allowable prospective cost. An adjustment shall be made to the usual rate effective October 1, 1990 (and continued until the cost shows in the cost report used to set the facility's rate) to account for those medical supplies, cathethers, syringes, and diapers not payable under the pharmacy element and now covered as routine NF cost.

NF/MRSs. These facilities shall be excluded from the facility cost arrays and have an upper limit set at 120 percent of the upper limit for freestanding facilities with the comparison made against the appropriate urban or rural array.

Swing-beds. Swing-bed data are excluded from the facility cost arrays. The swing-bed rates shall change effective January 1, 1991, and be based at that time on the average of NF payments for the preceding calendar year.

Dual-licensed Hospital Beds. Dual-licensed hospital provided patient days shall be excluded from the arrays and paid for at the hospital based facility upper limits.

Head Injury Units. NF units designated and recognized by the Medicaid agency as providing special treatment for head injury patients shall be excluded from the arrays and paid in accordance with previously specified rates.

Ventilator Care Facilities. Facilities recognized as providing ventilator dependent care shall be excluded from the arrays and paid in accordance with previous methodology (i.e., at a fixed rate based on allowable cost).

Nurse Aide Training and Medical Director Costs. The Medicaid agency will add .38 cents to facility rates for nurse aide training

costs attributable to replacement of nurse aides in training or testing status and .04 cents for medical director costs through June 30, 1991. (These add-ons are not payable for NF services provided in swing beds and dual licensed hospital beds.) The other nurse aide training costs will be paid as an administrative cost upon submission of appropriate claims and cost documentation by facilities experiencing training and testing costs.

Other OBRA Nursing Home Reform Costs. Effective October 1, 1990, and thereafter facilities will be required to request pre-authorization for costs that must be incurred to meet OBRA 87 Nursing Home Reform costs in order to be reimbursed for such costs. The preauthorization must show the specific reform action that is involved and appropriate documentation of necessity and reasonableness of cost. Upon authorization by the Medicaid agency, the cost may be incurred. A request for a payment rate adjustment may then be submitted to the Medicaid agency with documentation of actual cost incurred. The allowable additional amount will then be added on to the facility's rate (effective with the date the additional cost was incurred) without regard to upper limits or the CSI factor (i.e., the authorized Nursing Home Reform cost will be passed through at 100 percent of reasonable and allowable costs). Preauthorization is not required for nursing home reform costs incurred during the period July 1, 1990, through September 30, 1990; however, the actual costs incurred will be subject to tests of reasonableness and necessity and must be fully documented at time of the request for rate adjustment. Facilities may request multiple preauthorizations and rate adjustments (add-ons) as necessary for implementation of nursing home reform. Facility costs incurred prior to July 1, 1990, will not (except for the costs previously recognized in a special manner, i.e., the universal precautions add-on and the nurse aide training add-on) be recognized as being nursing home reform costs. The special nursing home reform rate adjustments must be requested using forms and methods specified by the agency. A nursing home rate adjustment will be included within the cost base for the facility in the rate year following the rate year for which the adjustment was allowed. No interim rate adjustments for nursing home reforms will be allowed for periods after June 30, 1992.

Intermediate Care Facilities for the Mentally Retarded. ICF-MRs shall continue to be paid on the basis of full reasonable allowable cost, using standards for reasonableness and allowability as shown in the Nursing Facility Reimbursement Manual (Exhibit B) with a cost incentive and investment factor (CIIF) schedule used in the same manner as before implementation of the Nursing Facility Reimbursement System. ICF-MR payments shall be made without comparison to usual and customary or actual billed charges of the provider on a per diem, annual aggregate or other basis. ICF-MRs shall be permitted an adjustment to the usual rate effective October 1, 1990 (and continued until the cost is shown in the cost report used for rate setting) to account for those medical supplies, cathethers, syringes and diapers not covered under the pharmacy element and now covered as routine cost.

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RESIDENT ASSESSMENT

Under the CMAR system there will be eleven assessment classifications. The classifications reflect the care needs of the resident. All assessments will be made by registered nurses based on information available at the time of assessment.

The items considered in performing this assessment and classification are based on 8 activities of daily living and three additional variables considered in completing the assessment which are behavior, special nursing procedures, and clinical monitoring.

A. A resident must be assessed as being dependent or independent in the Key Activities of Daily Living (ADLs) listed below:

		Not Dependent	Dependent
1.	Dressing	0-1	2-4
2.	Grooming	0-1	2-3
3.	Bathing	0-3	4-5
4.	Eating	0-1	2-4
5.	Bed Mobility	0-1	2-3
6.	Transferring	0-1	2-4
7.	Walking	0-1	2-4
8.	Toileting	0	1-6

B. A resident must be defined as special nursing if the resident meets the criteria in item 1. or 2.

1. The resident is assessed to require tube feeding; or

2. the resident is assessed to require clinical monitoring every day on each shift and the resident is assessed to require one or more of the following special treatments:

   a. Oxygen/Respiratory Therapy
   b. Ostomies/Catheter
   c. Wound/Decubiti Care
   d. Skin Care
   e. Rehabilitation Procedures
   f. Toileting (Bladder)
   g. Toileting (Bowel)
   h. Hyperalimentation
   i. Intravenous Fluids
   j. Intravenous Medications
   k. Blood Transfusions
   l. Drainage Tubes
   m. Symptom Control
   n. Isolation Precautions

C. The resident must be assessed to identify any existing behavior problems. If behavior problems are present, staff intervention and/or staff management must be determined.

D. A resident must be defined as having a neuromuscular condition if the resident is assessed to have one or more of the diagnoses coded to the categories in items 1. to 8. according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

1. Diseases of nervous system excluding sense organs (320-359 excluding 331.0);

2. cerebrovascular disease (430-438 excluding 437);

3. fracture of skull (800-804) excluding cases without intracranial injury;

4. intracranial injury, excluding those with skull fractures (850-854);

5. fracture of vertebral column with spinal cord injury (806);

6. spinal cord injury without evidence of spinal bone injury (952);

7. injury to nerve roots and spinal plexus (953); or

8. neoplasms of the brain and spine (170.2, 170.6, 191, 192, 198.3, 198.4, 213.2, 213.6, 225, 237.5, 237.6, and 239.6).

E. For resident assessment criteria, see Instructions for Completing Resident Nursing Assessment Form, page 4, Individual Dependencies.

RESIDENT CLASSIFICATIONS

Residents will be classified in accordance with the following definitions:

A. A resident must be assigned to class A-1 if the resident is assessed as:

1. 0-3 ADL dependencies;
2. no defined behavioral problems; and
3. not defined special nursing.

B. A resident must be assigned to class A-2 if the resident is assessed as:

1. 0-3 ADL dependencies;
2. defined behavioral problems; and
3. not defined special nursing.

C. A resident must be assigned to class A-3 if the resident is assessed as:

1. 0-3 ADL dependencies; and
2. defined special nursing.

D. A resident must be assigned to class B-1 if the resident is assessed as:

1. 4-6 ADL dependencies;
2. no defined behavioral problems; and
3. not defined special nursing.

E. A resident must be assigned to class B-2 if the resident is assessed as:

1. 4-6 ADL dependencies;
2. defined behavioral problems; and
3. not defined special nursing.

F. A resident must be assigned to class B-3 if the resident is assessed as:

1. 4-6 ADL dependencies; and
2. defined special nursing.

G. A resident must be assigned to class C-1 if the resident is assessed as:

1. 7-8 ADL dependencies;
2. moderately dependent in the eating ADL;
3. not defined special nursing; and
4. no defined behavioral problems.

H. A resident must be assigned to class C-2 if the resident is assessed as:

1. 7-8 ADL dependencies;
2. moderately dependent in the eating ADL;
3. defined behavioral problems; and
4. not defined special nursing.

I. A resident must be assigned to class C-3 if the resident is assessed as:

1. 7-8 ADL dependencies;
2. very dependent in the eating ADL;
3. not defined special nursing; and
4. no defined neuromuscular condition.

J. A resident must be assigned to class C-4 if the resident is assessed as:

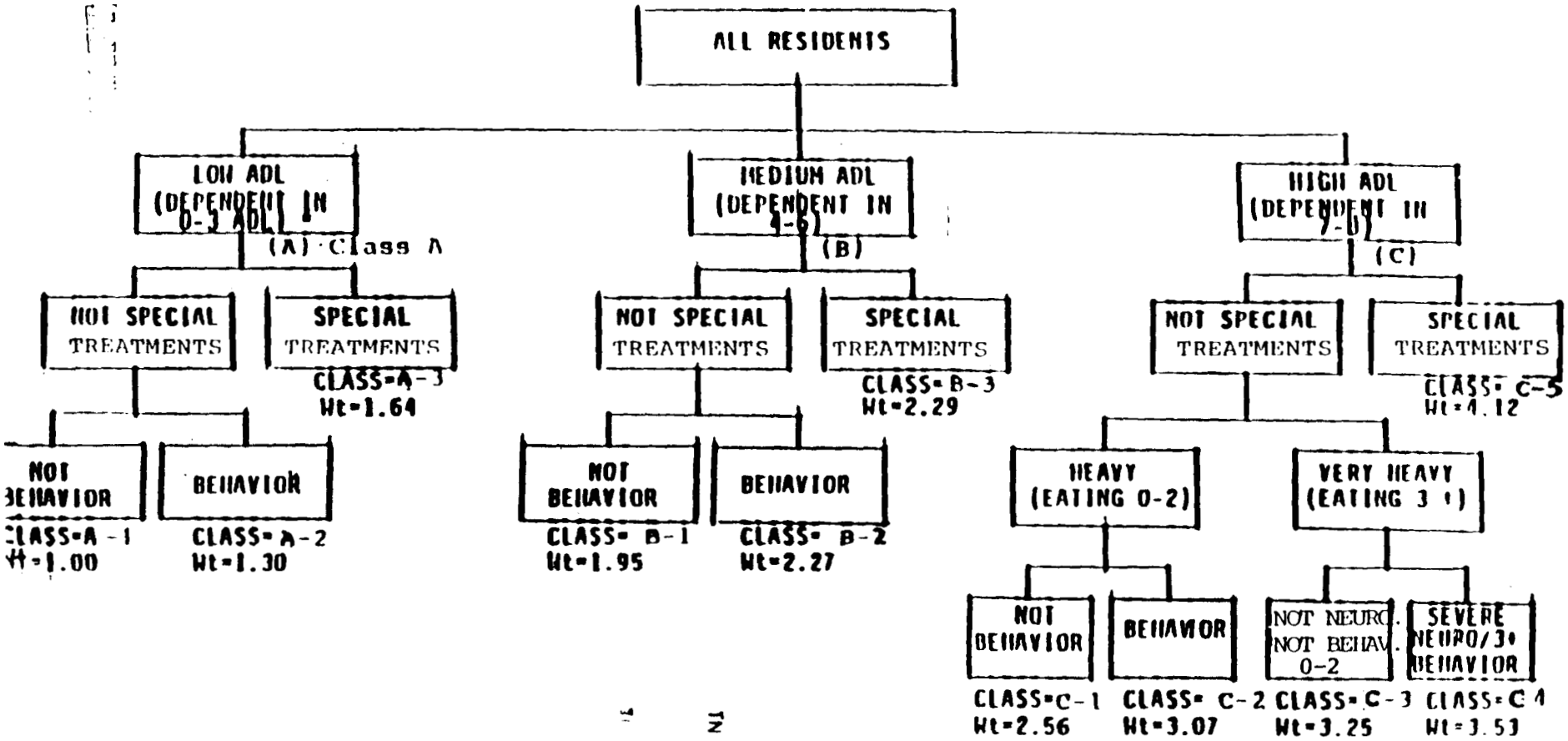
1. 7-8 ADL dependencies;
2. very dependent in the eating ADL;
3. not defined special nursing; and
4. defined neuromuscular condition or extreme behavior problems.

K. A resident must be assigned to class C-5 if the resident is assessed as:

1. 7-8 ADL dependencies; and
2. defined special nursing.

A classification determination chart follows which illustrates the decision process utilized in the above definitions.

Decision Tree



Activities of Daily Living (ADL's)

	Not Dependent	Dependent
Dressing	0-1	2-4
Grooming	0-1	2-3
Bathing	0-3	4-6
Eating	0-1	2-4
Bed Mobility	0-1	2-3
Transferring	0-1	2-4
Walking	0-1	2-4
Toileting	0	1-6

TN No 90-06
SUPERSEDES
DATE/APPROVED 9/28/90
DATE/EFFECTIVE 10/1/90

Classification	Weight (Relative Resource Use)
Low ADL	1.00
Low ADL Behavior	1.30
Low ADL Special Nursing	1.64
Medium ADL	1.95
Medium ADL Behavior	2.27
Medium ADL Special Nursing	2.29
High ADL	2.56
High ADL Behavior	3.07
Very High ADL (Eating 3-4)	3.25
High ADL Severe Neurological Impairment/3+Behavior	3.53
High ADL Special Nursing	4.12